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MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.

MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A: MEMBER INFORMATION	DEPENDENT INFORMATION
NAME:_____	**NAME:**_____
SOCIAL SECURITY NUMBER (SSN)_____ _	**SSN**_____
ADDRESS:_____	**ADDRESS:**_____
TELEPHONE ( )_____	**DATE OF BIRTH:**_____

PART B: DEPENDENT AUTHORIZATION: *The **dependent**, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:*

I hereby authorize my attending physician_____ to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

PHYSICIAN PART C: *The **physician** is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.*

Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor,
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from _____ to _____; At intervals of _____. I last examined the patient on _____.
2.	Medical History (related to disability): Date of Disability Onset:_____
3.	Diagnosis (REQUIRED): _____ ICD-9 Disease Code, Primary (Required) : _____ ICD-9 Disease Code(s), Secondary : _____ DSM IV Code(s) (if any) : _____
4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)
5.	Current Treatment(s) and /or Medication(s): (rendered to the patient for this disability): □ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable)

(See Page Two of this for additional required information.)

MEMBER:_____ DEPENDENT NAME:_____
SSN: _____ SSN: _____

Medical Report	
6	Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support. **Mobility Skills**: ____walking, ____sitting, ____standing, ____lifting, ____bending **Self-Care Skills**: ____feeding, ____bathing, ____toileting, ____dressing **Sensory Skills**: ____hearing, ____seeing, ____speech, ____touch **Cognitive Skills**: ____judgment, ____memory, ____planning/follow through, ____thinking/processing information
7.	Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that effect the patient's ADLs and limit his or her capacity to be self-supporting:

PART D: Medical Certification of Disability and Incapacity of Self Support: For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   ____ NO, the patient does NOT have a physically of mentally disabling injury, illness or condition.
   ____ YES (please answer Question 2)

2. In your medical or psychiatric opinion, (please select **A**, **B**, or **C**):
   ____**A**. The patient's current disability DOES NOT render him or her incapable of self-support.

   ____**B**. The patient's current disability DOES render him or her incapable of self-support but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
   (projected DATE—mm / yy)
   If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.
   Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.

   ____**C.** The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a _____, _____
(Type of Physician) (Specialty, if any)
licensed to practice by the State of _____.

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ (_____)_____
CITY STATE TELEPHONE NUMBER

_____ (_____)_____
DATE FAX NUMBER

PART E: CalPERS USE ONLY:

____ Claim approved for enrollment through _____ _____
DATE (for next review) REVIEWED BY

____ Claim rejected. _____
DATE